

A collaborative approach using a subepidermal moisture device along with nursing skin assessment to determine efficacy of current practice in preventing hospital-acquired pressure injuries a comprehensive cancer center.

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TOPIC

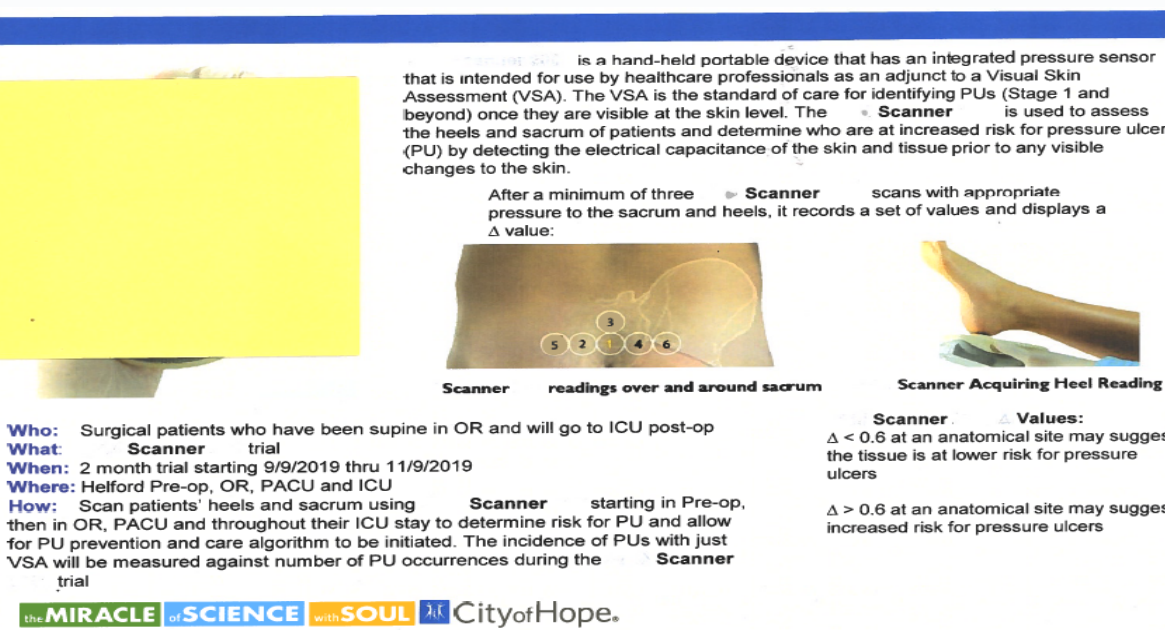
A concern regarding variation in nursing assessment skills led to an evaluation of using a skin moisture measuring device to validate nurse skin assessment findings

OBJECTIVES

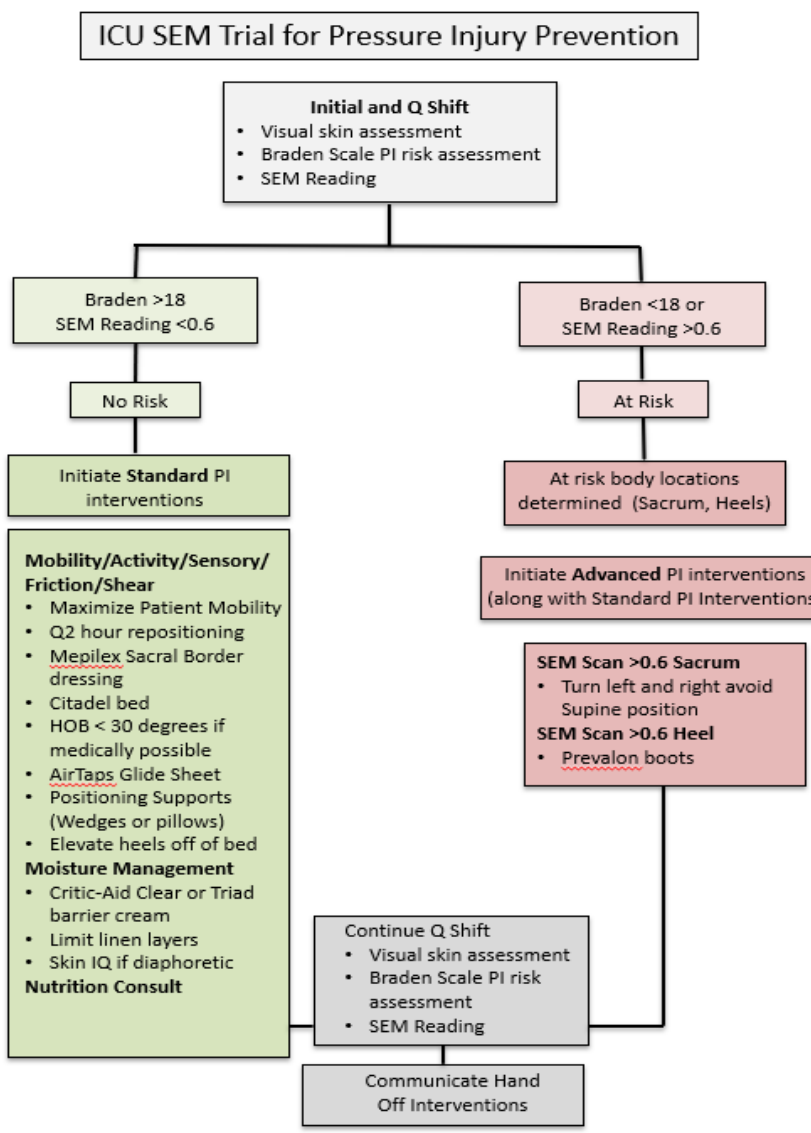
An evaluation of collaborative skin assessment and the use of a moisture measuring device concluded minimum value added to an already robust clinical nurse assessment and intervention process that identified patients with a high risk of pressure related skin injuries five days prior to their occurrence.

PROCESS

A leadership team implemented a practice change to include using a skin moisture scanner during visual skin assessment. The objective of this additional instrument was to highlight innovative technology for the advancement of nursing assessment, and increasing patient satisfaction and overall patient outcomes.



PROCESS



The utilization of a standardized nursing skin assessment process validated by the hospital's WOCN included: visual skin assessment, Braden Scale Pressure Injury Risk assessment, and a moisture measuring device algorithm

PROCESS

The data collection tools included a scanner data sheet, a checklist and a nursing script for interacting with patients. A re-evaluation of processes and bi-weekly data monitoring via meetings were done to ensure a standardized approach in consistent patient care

PATIENT NAME		DATE	BRACON SCORE	AREA	REDNESS	DELTA	Woundcare	Intervention/s added if delta equal or greater than 2
PICO	OK	Right heel	U	U	U	U	Standard	Wound Consult
		Right heel	U	U	U	U	Standard	Wound Consult
		Left heel	U	U	U	U	Standard	Wound Consult
		Left heel	U	U	U	U	Standard	Wound Consult
		Right heel	U	U	U	U	Standard	Wound Consult
PICO	OK	Right heel	U	U	U	U	Standard	Wound Consult
		Right heel	U	U	U	U	Standard	Wound Consult
		Left heel	U	U	U	U	Standard	Wound Consult
		Left heel	U	U	U	U	Standard	Wound Consult
		Right heel	U	U	U	U	Standard	Wound Consult
PICO	OK	Right heel	U	U	U	U	Standard	Wound Consult
		Right heel	U	U	U	U	Standard	Wound Consult
		Left heel	U	U	U	U	Standard	Wound Consult
		Left heel	U	U	U	U	Standard	Wound Consult
		Right heel	U	U	U	U	Standard	Wound Consult
PICO	OK	Right heel	U	U	U	U	Standard	Wound Consult
		Right heel	U	U	U	U	Standard	Wound Consult
		Left heel	U	U	U	U	Standard	Wound Consult
		Left heel	U	U	U	U	Standard	Wound Consult
		Right heel	U	U	U	U	Standard	Wound Consult
PICO	OK	Right heel	U	U	U	U	Standard	Wound Consult
		Right heel	U	U	U	U	Standard	Wound Consult
		Left heel	U	U	U	U	Standard	Wound Consult
		Left heel	U	U	U	U	Standard	Wound Consult
		Right heel	U	U	U	U	Standard	Wound Consult

CHECKLIST:

- SCAN patient in PREOP upon arrival
- SCAN patient in OR upon arrival
- SCAN patient in PACU upon arrival
- SCAN patient in ICU upon arrival and each shift until discharge

Script:

Hello my name is _____

and over the next couple of months our department will be utilizing a scanner to check your heels and sacrum for any skin issues. We will continue to scan your heels and sacrum throughout your hospitalization as well as provide preventative measures to main your healthy skin.

PATIENT SELECTION

Scanning of patient's heels and sacrum using a moisture measuring device began in the preoperative setting, moving into the operating room suite, then post anesthesia care unit, with a final disposition to intensive care unit. This serial skin assessment identified patients' heightened risk for developing pressure injury, supporting pressure injury prevention and care algorithm protocol to be initiated.

PATIENT SELECTION

- 30 patients scanned
- Patient Selection Criteria:
 - OR scheduled case duration over 6 hours
 - OR cases in the supine position only
 - No Vasopressor in the ICU
- Patients Scanned throughout the perioperative and post-op process
 - Preoperative bay, Operating Room, Post Anesthesia Care Unit (PACU), Intensive Care Unit (ICU)
- Scanning Process:
 - Heels and sacrum scanned using a moisture measuring device

OUTCOME

Incidence of pressure injury with visual skin assessment was measured against the number of pressure injury occurrences during the two-month trial, results suggested current nursing interventions promoting mobility, activity, sensory, friction and shear interventions along with moisture management and nutritional consult provided an optimal approach in reducing pressure

OUTCOME

Perioperative (Pre-operative, Operating Room and Post Anesthesia Care Unit):

Average procedure duration in minutes = 440 minutes

Patients were positioned supine on foam head rest, pillows under knees and foam pad under their ankles during surgery. (*Note: 3 patients were excluded from the trial because they were not supine during surgery.) Sacral foam dressing were also applied to all patients in pre-op.

ICU:

Average length of stay =1.54 days

All patients received standard PI prevention interventions. One patient was given vasopressors.

[illegible]

OUTCOME

There were missed opportunities in scanning patients for sub-epidermal moisture during their perioperative and intensive care unit stays. Data derived from the sub-epidermal moisture scans did not require patients to receive advanced PI management. Standard PI interventions were implemented on all patients and none developed PI during their perioperative and intensive care stays.